PATIENT INFORMATION/COMPUTER FORM

(Ages 0 – 18)

CLINIC DATE:_____

CHILD'S NAME:_____

ADDRESS:_____ _____
Street or P.O. Box City Zip

PHONE:_____ SEX:_____ DATE OF BIRTH:_____ AGE:_____

PARENT/GUARDIAN:_____ PHYSICIAN:_____

ALLERGIES:_____ CURRENT MEDICATIONS:_____

PREVIOUS SERIOUS VACCINE REACTIONS:_____

THE FEDERAL "VACCINES FOR CHILDREN" (VFC) PROGRAM REQUIRES THAT WE KEEP STATISTICS ON ALL CHILDREN IMMUNIZED IN OUR CLINICS. IN ORDER TO COMPLY WITH THIS, WE ASK YOU TO RESPOND TO THE FOLLOWING QUESTIONS. (ALL INFORMATION IS CONFIDENTIAL).

1. RACE: ☐ Caucasian ☐ American Indian/Alaskan Native ☐ Black ☐ Asian/Pacific Islander ☐ Hispanic ☐ Unknown ☐ Other
2. IS CHILD ON MEDICAID? ☐ YES ☐ NO
   If YES, CHILD'S NAME AS LISTED ON MEDICAID CARD: _____
   MEDICAID NUMBER:_____
3. IS CHILD COVERED BY MEDICAL INSURANCE? ☐ YES ☐ NO
4. IF YES, DOES IT COVER IMMUNIZATIONS? ☐ YES ☐ NO

FOR NURSES USE ONLY

Liz/forms/shotform new roi 7/27/05

MFG Lot #	MFG Lot #	MFG Lot #	MFG Lot #	MFG Lot #	MFGLot #	MFG Lot #	MFG Lot #	MFG Lot #	MFG Lot #
DtaP/IPV/Hep B 1 2 3 *Site:* LTIM RTIM	**DtaP** 1 2 3 4 5 *Site:* LTIM RTIM LDIM RDIM	**TdaP Boostrix** (10–18 yrs) *Site:* LDIM RDIM	**TdaP Adacel** (11-55 yrs) *Site:* LDIM RDIM	**IPV** 1 2 3 4 5 *Site:* LTSQ RTSQ LDSQ RDSQ	**HIB** 1 2 3 4 *Site:* LTIM RTIM LDIM RDIM	**PREVNAR** 1 2 3 4 *Site:* RTIM LTIM	**MMR** 1 2 *Site:* LDSQ RDSQ	**VARICELLA** 1 2 *Site:* LDSQ RDSQ	**Td** 1 2 3 4 5 6 *Site:* RDIM LDIM
90723 V20.2	90700 V06.1	90715 V20.2	90715 V06.8	90713 V04.0	90648 V03.81	90669 V05.8	90707 V06.4	90716 V05.4	90718 V06.5

MFG Lot #	MFG Lot #	MFG Lot #	MFG Lot #	MFG Lot #	MFG Lot #	MFG Lot #	MFG Lot #
HEP A 1 2 *Site:* LTIM RTIM LDIM RDIM	**HEP B** 1 2 3 Site: LTIM RTIM LDIM RDIM	**MENINGOCOCCAL MENINGITIS** 1 2 *Site:* **Menactra** LDIM RDIM **Menomune** SQ LD SQ RD	**YELLOW FEVER** *Site:* RASQ LASQ	**TYPHOID** 1 2 *Site:* RTIM LTIM RDIM LDIM ORAL	**TB** *Site:* RAV LAV	**TB Results** POS. NEG. _____ mm Checked by: _____	**FLU** *Site:* RDIM LDIM LTIM RTIM
90633 V05.3	90744 V05.3	90733 V03.82	90717 V04.4	90691 V03.1	86585 V74.1		**6 mos - 35 mos** 90655 V04.8 **36 mos-18 yrs** 90657 V04.8

Nurses Signature:_____

Date:_____ Recall date:_____

Comments:

Name:_____

Please read carefully and fill out. (Circle Yes or No) The nurse will discuss with you any yes response and evaluate if your child should receive the vaccine.

YES	NO	My child is allergic to chicken eggs (anaphylactic reaction: hives, swelling of mouth and throat, difficult breathing). **(Yellow Fever)**
YES	NO	My child is allergic to yeast (anaphylactic reaction: hives, swelling of mouth and throat, difficult breathing). **(HEP B vaccine)**
YES	NO	My child is taking corticosteroids. **(MMR,Varicella vaccines)**
YES	NO	My child has active tuberculosis. **(MMR, Varicella vaccines)**
YES	NO	My child has cancer, leukemia, immune problems or another chronic disease. **(MMR, OPV, Varicella vaccines)**
YES	NO	My child lives with someone who is being treated for cancer, has problems with their immunity, or has another serious illness. **(Varicella vaccines)**
YES	NO	My child is allergic to gelatin. **(Varicella vaccine)**
YES	NO	My child is allergic to Neomycin. **(MMR, IPV, Varicella vaccines)**
YES	NO	My child is allergic to Streptomycin or Polymixin B. **(IPV vaccine)**
YES	NO	My child has had convulsions or seizures. **(DPT, DTaP vaccines)**
YES	NO	My child is allergic to Thimerisol. **(Flu vaccine)**
YES	NO	My child has had an acute illness with fever in the last twenty-four (24) hours.
YES	NO	My child has received blood products (such as immune globulin or a transfusion) during the past several months. **(Varicella, MMR vaccines)**
YES	NO	My child's family has a history of congenital or hereditary immune problems. **(Varicella vaccine)**
YES	NO	My child is allergic to Latex **(Flu vaccine)**

ACKNOWLEDGEMENT AND CONSENT – PLEASE INITIAL

_____ I have read or have had explained to me the information contained in the Vaccine Information Statement(s) about the disease(s) and the vaccine(s). I have had a chance to ask questions which were answered to my satisfaction.

_____ I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated below be given to me or to the person named above for whom I am authorized to make this request.

_____ I have received and reviewed the Notice of Privacy Practices, which provides a description of information uses and disclosures.

_____ I consent to the shared use of demographic information that is provided for immunization and/or maternal/child health purposes.

_____ _____

Signature of Patient or Legal Representative *Date*

_____ _____

Witness *Date*